Patient Safety Innovation Award - 2019 Nomination Form

For questions about submitting a nomination for the award, contact Casey Hutchens chutchens@IHAconnect.org.

Overview

The Indiana Patient Safety Center (IPSC) has established the annual Patient Safety Awards to recognize individuals, groups and organizations who have helped bring Indiana closer to the goal of zero patient harms. These awards will honor commitment and enthusiasm for improving patient safety in hospitals and communities across the state.

The Patient Safety Innovation Award recognizes an individual, group or program that has developed innovative ways to improve, encourage or enhance patient safety within their hospital, health system, regional patient safety coalition or professional organization. This could mean developing a new program, process or campaign or leveraging an existing process or tool in a new way. Winners will demonstrate creativity and forward thinking.

Submit your nomination by filling out the following form and submitting a brief narrative. Supporting documents may be attached to enhance your nomination.

The nomination period is open from Feb. 25 to April 8. Nominations will be carefully considered by a committee of health care professionals and patient safety advocates, with winners announced at the Patient Safety Summit June 4.

2018 Winner: The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital

The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital received the 2018 Patient Safety Innovation Award for their outstanding work improving continuity of care medication safety by targeting high-risk patients to receive a TOC pharmacist evaluation of patient's medication therapy. Through this unique approach to patient care, the team at Franciscan Health Hammond Hospital removed patient care silos by bridging the gaps in care in all aspects of a patient's healthcare experience. The Comprehensive Transitions of Care (TOC) Pharmacy Program was created to bridge gaps in transition of care from the hospital to home and, ultimately, decrease hospital readmissions of high-risk patients.

2019 Nomination Form

NOMINATOR INFORMATION

Name *

Lacy Veyon

Job Title *

Patient Safety Coordinator

Hospital/Organization *

Henry Community Health

Address *

1000 N. 16th St. New Castle, IN 47362

Email *

lveyon@hcmhcares.org

Phone Number *

(765-)599-3884

NOMINEE INFORMATION

I am nominating a(n) *

- ○ Individual
- ◉ Group/Team/Coalition
- ○ Organization

If group, team, coalition, or organization, please include name

Sepsis Team

Contact Name *

Kris Larson

Job Title *

Quality Coordinator

Hospital/Organization *

Henry Community Health

Address *

1000 N. 16th St. New Castle, IN 47362

Email *

klarson@hcmhcares.org

Phone Number *

(765-)599-3128

NOMINATION REASONING

Please write a brief narrative below that describes why this nominee deserves to be recognized. Please incorporate the answers to the following questions in your narrative based on the award you indicated above.

Write response here *

Many organizations are struggling with the complexity of the SEP-1 measure and HCH is among them with SEP-1 compliance rate of 36% for the 4th quarter of 2017. We found we did not have standardization between the departments for providing sepsis care. Our sepsis initiative allowed standardization of care leading to improved compliance with the SEP-1 measure and better patient outcomes. A sepsis team comprised of ED and ICU nurses and Quality began meeting in February of 2017 at which time our compliance rate had plummeted to 16%. As time went on more members were added to our team. We now have an interdisciplinary team including the Chief Medical Officer, Chief of Emergency Department, the Quality Coordinator, and the Safety Coordinator, nursing from three departments, representation from laboratory, pharmacy, informatics, and clinical documentation.

Our efforts began to be more successful in June of 2018 when our hospitalist program became fully staffed with permanent providers, previously the majority of our hospitalists were locums. We have seen a steady improvement through our efforts ending 2018 with a compliance rate of 50.6%, meeting the goal of 50% we had set for ourselves.

When one area is working it seems another is failing. We began the process looking at where each of our failures occurred and focused on items that occurred early in the three hour bundle. One of these items was the administration of IV fluids. The issue had two parts, the first being that providers were not always ordering the correct volume and, the second was that nursing was not completing the entire volume within the appropriate timeframe. One way we addressed the issue of the providers not ordering the correct volume was to standardize the IVF order in the sepsis order sets. Previously there had been multiple orders for providers to choose, we removed all of them except the order that calculated the volume as 30 ml per kg of body weight. The second problem was addressed with the development of a system in which nursing can easily visualize the amount of IV fluids to still be infused. When the initial bolus is ordered the nurse will remove all the needed bags and label them with stickers to indicate which bag (i.e. #1, #2, #3) and the amount needed to be infused from each bag (i.e. 1000ml, 1000ml, 450ml). All of the IV bags are kept with the patient until the bolus is completed. Any nurse who may address the empty IV bag will immediately know if another bolus bag needs to be hung.

Our efforts were shared at a recent SHIP sepsis training session. Several of the hospitals present were interested in duplicating some of our practices

PATIENT SAFETY INNOVATION AWARD

Please complete all questions below.

What patient safety initiative has this individual/group/organization created or led? *

Improvement in Sepsis Care

What need did this initiative fill, or what problem did it solve? *

HCH had poor compliance with the Sep-1 CMS measure and found there were no clear guidelines in place for providing sepsis care. The initiative allowed standardization of care leading to improved compliance with the SEP-1 measure and better patient outcomes.

What made this initiative innovative or unique from existing efforts? *

We developed a system in which nursing can easily visualize the amount of IV fluids to still be infused. When the initial bolus is ordered the nurse will remove all the needed bags and label them with stickers to indicate which bag (i.e. #1, #2, #3) and the amount needed to be infused from each bag (i.e. 1000ml, 1000ml, 450ml). All of the IV bags are kept with the patient until the bolus is completed. Any nurse who may address the empty IV bag will immediately know if another bolus bag needs to be hung.

What results did this initiative produce? *

Increased compliance with Sepsis Bundles resulting in better patient outcomes.

Has this innovative initiative been recognized by other individuals or groups, or has it been replicated by others since its implementation? *

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